DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE NORTH (PAGE) (PAGE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
WESTMINSTER VILLAGE MORTH (PA) ID (PA			155167	B. WING				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS REFERENCED TO THE APPROPRIATE CARDINARY OR LSC IDENTIFYING INFORMATION TAG CROSS REFERENCED TO THE APPROPRIATE CARDINARY OF LSC IDENTIFYING INFORMATION	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR			27/2013
This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00162694 completed January 27, 2015. This visit was in conjunction with the Investigation of Complaint IN00164061. Complaint IN00162694- Corrected. Survey dates: February 25, 26, and 27, 2015 Facility number: 000084 Provider number: 155167 AIM number: 100284600 Survey team: Chuck Stevenson RN Census bed type: SNF/NF: 130 Total: 130 Census payor type: Medicare: 29 Medicaid: 58 Other: 43 Total: 130 Sample: 3 Westminster Village North was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 162:3.1 in regard to the PSR to the Investigation of Complaint IN00162694. Quality review completed on March 2, 2015 by Cheryl Fielden, RN.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	<	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
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		Cheryl Fielden, RN.						

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PE	ROVIDER OR SUPPLIER	155167		STREET ADDRESS, CITY, STATE, ZIP CODE			
				11050 PRESBYTERIAN DR			
WESTMINS	STER VILLAGE NORTH			INDIANAPOLIS, IN 46236			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE		